STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

SEP 2 6 2003

The Honorable Ulysses Currie, Chair
Senate Budget & Taxation Committee
Miller Senate Office Building, 3 West Wing
11 Bladen Street
Annapolis MD 21401-1991

The Honorable Howard P. Rawlings
House Appropriations Committee
Lowe House Office Building, Room 131
84 College Avenue
Annapolis MD 21401-1991

RE: Page 119 of the *2003 Joint Chairmen's Report*

Dear Chairmen Currie and Rawlings:

In accordance with the *2003 Joint Chairmen's Report*, the Department of Health and Mental Hygiene is required to submit a report on the Alcohol and Drug Abuse Administration's distribution of substance abuse treatment and prevention funds for jurisdictions before $1 million in general funds are released. The enclosed report, as required, includes funds allocated to and reverted by each jurisdiction for a specified period, and an explanation of how funds are currently allocated. The report includes possible criteria, expressed in a formula, by which future allocations may be made.

If you have any questions, please feel free to contact Peter F. Luongo Ph.D., Director of the Alcohol and Drug Abuse Administration. Dr. Luongo may be reached on (410) 402-8610.

Sincerely,

Nelson J. Sabatini

Nelson J. Sabatini
Secretary

Enclosure

cc: Arlene Stephenson
Peter F. Luongo
James Johnson
Karen Black

Introduction

The General Assembly's *2003 Joint Chairmen's Report (JCR)* requires the Alcohol and Drug Abuse Administration to report on the distribution of substance abuse treatment and prevention funds by jurisdiction. The report includes funds allocated to and reverted by each jurisdiction (five years of allocation/award data and the most recent three years for reversions), an estimate of unmet need and an explanation of how funds are currently allocated. The report includes possible criteria, expressed in a formula, by which future allocations may be made, as well as an illustration of the redistribution of the FY 04 allocation using that formula.

Current Methods of Allocating Funds

There are four methods that are used to distribute alcohol and drug abuse grants in Maryland. The methods are by historic allocation, by legislative award, by competitive process, or by formula. Each will be discussed in relation to the FY 04 allocations.

- Historic allocation is the method that uses percentage distribution implied by the prior year's allocation to determine the current year's allocation. The derivation of the original allocation does not exist in any documentation but was likely influenced by local facility and resource availability, as well as a jurisdiction's or agency's desire to provide particular services. In the early days of public funding for substance abuse services, individual programs applied directly to DHMH for funding. Thus, private not-for-profit programs were direct awardees and their influence is still apparent in the awards to jurisdictions. The ADAA (and its predecessor entities, the Alcoholism Control Administration and the Drug Abuse Administration) has been awarding grants since at least 1969. In FY 04 approximately $55.9 million or 49 percent of ADAA awards to jurisdictions are historic allocations.

- Legislative award is the method that the General Assembly uses to direct the ADAA to provide funding to specific jurisdictions, or to provide funding for specific services (e.g Child Welfare Initiative, Drug Affected Babies Initiative, etc.). In FY 04 approximately $29 million, or 26 percent of ADAA awards to jurisdictions are the result of legislative directives.

- Competitive award is the method designated by law for the Substance Abuse Treatment Outcomes Partnership (STOP). This grant requires a match from the applicant jurisdiction. Budget language precludes Baltimore City from participating in the STOP program. Originally planned as a program with a three year expansion starting with $4 million in FY 02, and growing to $12 million in FY 04, this grant program was reduced by the 2003 General Assembly by $5.59 million. The ADAA also uses the competitive process for a portion of the prevention portfolio funded by the Federal Substance Abuse Prevention and Treatment Grant. In FY 04 approximately $7 million, or 6 percent of ADAA awards to jurisdictions are the result of the competitive award process.

- Formula awards distribute grant funds by certain agreed upon criteria, a process explicitly delineating a need. The initial use of a formula for jurisdictional allocations was by the Governor's Drug Treatment Task Force. The Task Force conducted a needs assessment to decide on the distribution of Cigarette Restitution Funds to each jurisdiction.[1] More recently the Regional Needs grant program devised a funding formula to allocate $4.5 million to jurisdictions and regions.[2] For FY 04 approximately $21.5 million, or 19 percent of ADAA awards to jurisdictions are allocated by formula.

The table below summarizes the distribution of FY 04 awards to jurisdictions by method of allocation.

Method of Allocation	Award	Percent of Total Award
Historic	55,946,822	49%
Legislative	29,029,441	26%
Competitive	7,010,000	6%
Formula	21,515,181	19%
Total	113,501,444	100%

In summary, the primary method of allocation is by historic award, followed by over a quarter of the funds designated by the legislative award method. A quarter of the funds are distributed competitively and by formula.

FY 2000 – 2004 Allocations

Treatment and prevention funds distributed to jurisdictions increased from $60.5 million in FY 00 to almost $113.2 million in FY 04. Some of those funds were dedicated to salary upgrades to address work force recruitment and retention issues, as well as infrastructure development in the jurisdictions. This reflects the fact that the ADAA grant program provides the basis for funding the infrastructure in Maryland's jurisdictions. By and large, however, ADAA funds were primarily used for treatment expansion.

The table on the following page details treatment and prevention funding by jurisdiction for FY 2000 – 2004. Statewide programs operated by jurisdictions (Allegany and Carroll Counties) have been removed from the analysis as are statewide contracts directly procured by ADAA since these programs are available to all state residents. Award amounts reflect FY 03 cost containments and FY 04 reductions, to date.

[1] See, *Drug Treatment Task Force Final Report. Blueprint for Change: Expanding Access to and Increasing the Effectiveness of Maryland's Drug and Alcohol Treatment System. (2001)* for each jurisdiction's needs assessment.

[2] See; 2001 Joint Chairmen's Report, *Allocating Maryland's Substance Abuse Treatment Funding Via Formula*, ADAA and Carnevale Associates, for additional detail.

Alcohol and Drug Abuse Administration
Treatment and Prevention Funding by Jurisdiction
Fiscal Years 2000 - 2004

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
Allegany County	1,026,402	1,129,601	1,502,237	2,011,701	2,030,997
Anne Arundel Co	2,870,363	3,844,521	4,717,217	4,822,354	4,804,781
Baltimore Co	4,029,585	5,579,303	6,167,418	6,974,076	7,067,338
Calvert Co	641,801	787,761	917,218	1,189,081	1,206,846
Caroline Co	496,924	562,115	673,106	655,166	655,166
Carroll Co	1,150,207	1,294,074	1,458,443	1,567,511	1,526,691
Cecil Co	965,270	1,028,503	1,321,267	1,432,300	1,432,300
Charles Co	1,101,451	1,372,433	1,927,109	2,301,742	2,325,271
Dorchester Co	873,942	1,068,013	1,198,378	1,979,889	1,999,821
Frederick Co	1,749,455	1,821,881	2,508,884	2,666,208	2,659,842
Garrett Co	729,031	789,887	860,558	1,004,729	1,004,729
Harford Co	1,159,164	1,487,494	2,031,485	2,107,039	2,138,630
Howard Co	899,952	1,121,630	1,225,258	1,608,064	1,833,196
Kent Co	1,352,253	1,456,394	1,910,429	1,991,604	1,979,558
Montgomery Co	3,236,801	4,443,200	4,462,818	4,714,761	4,704,899
Prince George's Co	6,222,701	8,825,408	10,181,849	11,702,421	11,496,220
Queen Anne's Co	651,959	767,821	831,551	874,346	874,339
Somerset Co	724,474	862,463	1,067,564	1,087,135	1,087,135
St. Mary's Co	1,701,849	2,304,051	2,997,174	2,866,769	2,866,769
Talbot Co	683,126	782,851	852,585	954,030	938,990
Washington Co	2,398,882	2,840,904	3,381,262	3,870,400	3,870,400
Wicomico Co	1,384,469	1,737,281	2,099,759	2,318,868	2,318,868
Worcester Co	2,286,300	2,495,587	2,881,110	3,067,189	3,107,028
Baltimore City	22,161,240	33,787,941	41,845,160	48,079,642	49,571,630
Total	60,497,601	82,191,117	99,019,839	111,847,025	113,501,444

NOTE: FY03 column reflects 03 cost containment; FY04 column reflects 04 cost containment.
Figures do not include statewide programs in Allegany and Carroll Counties nor statewide contracts.

Reversion Analysis

Reversions refer to unexpended grant funds awarded to jurisdictions that are "reverted" back to the state when unspent during the grant year. Treatment and prevention fund reversions are expressed in both dollars and as a percentage of the jurisdiction's award. [3]

	FY 2000	FY 2001	FY 2002
Allegany	67,158 (2%)	107,501 (3%)	34,945 (<1%)
Anne Arundel	103,315 (4%)	61,800 (2%)	82,990 (2%)
Baltimore Co	0	78,841 (1%)	277,149 (5%)
Calvert	114,606 (18%)	63,674 (8%)	93,515 (10%)
Caroline	47,092 (10%)	59,273 (11%)	43,237 (6%)
Carroll	185,603 (6%)	233,736 (7%)	221,765 (5%)
Cecil	6,040 (<1%)	72,870 (7%)	70,097 (5%)
Charles	20,649 (2%)	81,030 (6%)	13,772 (<1%)
Dorchester	0	4,529 (<1%)	3,654 (<1%)
Frederick	124,319 (7%)	76,101 (4%)	204,518 (8%)
Garrett	0	0	152,120 (18%)
Harford	1,001 (<1%)	32,593 (2%)	156,589 (7%)
Howard	143,974 (16%)	195,272 (17%)	94,972 (8%)
Kent	2,036 (<1%)	22,347 (2%)	15,025 (<1%)
Montgomery	169,750 (5%)	454,244 (10%)	171,346 (4%)
Prince George's	41,898 (<1%)	1,862,906 (21%)	465,767 (5%)
Queen Anne's	27,542 (4%)	50,401 (7%)	73,794 (9%)
Somerset	98,333 (14%)	104,076 (12%)	13,574 (1%)
St. Mary's	42,287 (2%)	76,411 (3%)	115,127 (4%)
Talbot	5,695 (<1%)	3,547 (<1%)	103,853 (12%)
Washington	0	1,143 (<1%)	4,574 (<1)
Wicomico	25,593 (2%)	218,809 (13%)	155,906 (7%)
Worcester	37,338 (2%)	62,965 (3%)	34,014 (1%)
Baltimore City	726,921 (3%)	2,350,950 (7%)	2,577,533 (6%)
Total	1,990,151 (3%)	6,275,019 (7%)	5,179,836 (5%)

There are a number of factors related to fund reversions. Starting in FY 01 the state embarked on a significant funding expansion for treatment services. The budget grew from approximately $60.5 million in FY 00 to $99 million in FY 02.[4] New funds were awarded for a full year, but start ups generally did not occur until the last quarter of the fiscal year because of the local appropriation process, staff recruitment, acquisition of physical space and equipment for the program, and in the case of several jurisdictions, the

[3] FY 03 expenditure data is incomplete as of this writing. Complete data is reported for FY 2000 – 2002. Expenditures for state wide programs operated by Allegany and Carroll Counties are included as the fiscal reporting system configured for those years did not break out these expenditures.

[4] See table on page 3.

local procurement process needed to select a program operator. Absent new funds, staff turnover and vacancies would create modest fund reversions.

FY 2000 – 2002 Individuals Treated in ADAA Funded and Non Funded Programs
The following table presents the last three years of individuals treated by the jurisdiction in which the program was located. Another way to present this data is individuals served by jurisdiction of residence; both are valid, but different expressions of the same data. Displaying individuals served by the jurisdiction where the treatment occurred most closely reflects the method of fund distribution, which is by jurisdiction. Included in the analysis are both funded and non-funded programs. Also included is the number of individuals treated in state wide programs.

	FY 2000		FY 2001		FY 2002	
	ADAA Funded	Non-Funded	ADAA Funded	Non-Funded	ADAA Funded	Non-Funded
Allegany	947	61	908	36	939	84
Anne Arundel	634	5,323	637	5,636	698	5,912
Baltimore Co	3,366	3,367	3,462	3,742	3,528	4,795
Calvert	903	404	875	474	999	539
Caroline	295	0	304	0	344	0
Carroll	1,274	1,466	1,207	1,795	1,208	1,740
Cecil	638	368	708	593	893	723
Charles	1,000	172	1,113	163	1,342	0
Dorchester	464	531	476	888	460	1,234
Frederick	1,065	2,264	1,151	2,250	1,195	2,396
Garrett	310	134	262	164	310	224
Harford	998	2,341	1,133	2,593	1,299	2,951
Howard	627	1,536	609	1,515	610	1,866
Kent	459	0	513	0	621	0
Montgomery	1,603	3,621	1,302	4,230	2,335	4,044
Prince George's	2,069	3,353	2,043	4,270	2,215	4,601
Queen Anne's	522	0	427	0	374	0
Somerset	413	0	422	0	378	0
St. Mary's	814	93	1,204	98	1,384	100
Talbot	518	102	595	90	601	108
Washington	1,004	506	1,121	670	1,377	689
Wicomico	1,521	831	1,627	758	1,816	714
Worcester	763	123	815	133	905	146
Baltimore City	11,212	9,536	12,406	9,622	15,232	9,893
Statewide	692	NA	888	NA	832	NA
Total	34,111	36,132	36,208	39,720	41,895	42,759

This information is helpful in determining the gap between demand and number of individuals served.

Per Capita Spending for Treatment by Jurisdiction
This section details per capita spending for treatment by jurisdiction for FY 02.

Caution is advised in interpreting this information. A jurisdiction may provide only outpatient care (the least expensive level of care), not provide intensive outpatient (more expensive), and not provide residential services (the more expensive). Providing few levels of care skews per capita spending. Also skewing the figure is that publicly funded programs may include local, or other grant funds. These programs appear as publicly funded, but not all their funds are from the ADAA, but all of the patients are reported as public funded. Additionally, while these funds appear as treatment funds, they are also legitimately used by jurisdictions for assessment and case management, and for infrastructure. In one jurisdiction, Anne Arundel, the majority of individuals are treated in the private sector as self payers, although they originated with a referral from the public sector.[5] While a per capita measure makes intuitive sense, it is too influenced by other factors to provide much useful information. Similarly, these factors make it difficult to estimate funding per capita.

	Treatment Expenditures	Individuals Treated	Per Capita Expenditure
Allegany	1,340,681	939	1,428
Anne Arundel	4,438,451	698	6,359
Baltimore Co	5,440,461	3,528	1,542
Calvert	743,804	999	746
Caroline	552,954	344	1,607
Carroll	1,139,264	1,208	943
Cecil	1,179,183	893	1,320
Charles	1,785,422	1,342	1,330
Dorchester	1,100,438	460	2,392
Frederick	2,020,110	1,195	1,690
Garrett	484,659	310	1,563
Harford	1,721,012	1,299	1,325
Howard	1,035,643	610	1,698
Kent	1,796,522	621	2,893
Montgomery	3,903,140	2,335	1,672
Prince George's	9,399,730	2,215	4,244
Queen Anne's	693,835	374	1,855
Somerset	960,916	378	2,542
St. Mary's	2,788,900	1,384	2,015
Talbot	748,732	601	1,246
Washington	3,142,031	1,377	2,282
Wicomico	1,725,165	1,816	950
Worcester	2,748,402	905	3,037
Baltimore City	38,797,545	15,232	2,547

[5] See table on p 5. The per capita expenditure measure grossly distorts the treatment activity generated by the public sector in this jurisdiction.

Estimated Need for Treatment by Jurisdiction

The ADAA over the years has used several methodologies to estimate the number of individuals with alcohol and/or drug abuse/addiction disorders. Some methods have not yielded estimates for each jurisdiction, only regional and state wide estimates. One statistical technique, the Poisson method, produces an estimate using the actual number of individuals treated and the number of treatment episodes they account for in each jurisdiction. This method is used here and provides the best approximation of relative difference in the underlying need for treatment among the jurisdictions. FY 02 data is used to estimate need and to provide the actual number of individuals treated in all programs (ADAA funded and non-funded programs).[6] The treatment "gap" is the difference between need and actual number of individuals treated.

	Estimated Need	Actual Number Treated	Difference (Gap)
Allegany	3,767	1,023	2,744
Anne Arundel	29,941	6,610	23,331
Baltimore Co	35,519	8,323	27,196
Calvert	5,413	1,538	3,875
Caroline	2,537	344	2,193
Carroll	7,709	2,948	4,761
Cecil	5,860	1,616	4,244
Charles	9,377	1,342	8,035
Dorchester	2,591	1,694	897
Frederick	10,749	3,591	7,158
Garrett	1,414	534	880
Harford	12,932	4,250	8,682
Howard	7,773	2,476	5,297
Kent	1,844	621	1,223
Montgomery	16,988	6,379	10,609
Prince George's	22,559	6,816	15,743
Queen Anne's	2,597	374	2,223
Somerset	1,927	378	1,549
St. Mary's	6,786	1,484	5,302
Talbot	2,497	709	1,788
Washington	6,446	2,066	4,380
Wicomico	6,274	2,530	3,744
Worcester	3,765	1,051	2,714
Baltimore City	81,766	25,125	56,641
Total	289,031	83,822	205,209

[6] The estimate of need is for both adolescents and adults.

Overall, 29% of the estimated need for treatment was met in FY 02 (83,822 ÷ 289,031 = .29). ADAA funding provided treatment for 41,895 individuals, or approximately 50% of the total treated.[7]

Health planners expect that 25% of a population in need will come forward for treatment in a year. However, this standard does not seem adequate for planning for substance abuse treatment as it does not take into account the distribution of treatment by level of care (detoxification, outpatient, intensive outpatient etc.), nor the ample opportunities addiction presents for the individual to come into contact with multiple social agencies (criminal justice, child welfare etc.) in a year and be directed to treatment. While there is no formula to determine how much of this population to plan for, there is no doubt that it is not 25%.

Formula and Redistribution of FY 04 Funds

The formula discussed here was developed in response to the 2001 General Assembly's request for a formula to apply to a $4.5 million increase in substance abuse treatment funding. That report, *Allocating Maryland's Substance Abuse Treatment Funding Via Formula,* was submitted to, and approved by, the General Assembly, and was subsequently applied to the distribution.

The formula uses three "proxy" variables; an estimate of the individuals in each jurisdiction with an alcohol and/or drug problem; the number of HIV cases per jurisdiction, and the number of drug and DWI arrests per jurisdiction. These measures account not only for the number of individuals who have substance related disorders but the variables also are "proxies" for the health (HIV) and social problems (crime) that addiction presents to each community. The rationale for and source of each formula component follows. The method for estimating the need for treatment was discussed in the previous section and will not be repeated.[8]

- There is a relationship between intravenous drug use and HIV cases. The number of HIV cases can be considered a consequence of drug addiction and can be used reliably as a proxy. HIV data is from the Maryland AIDS Administration; *Maryland HIV/AIDS Epidemiological Profile, April 1, 2001 – March 31, 2002*.

- A set of social problems related to addiction are manifested by the nexus between crime and addiction. Thus, a crime measure can stand as a proxy for the problems resulting from addiction. To ensure that the crime measure is a direct result of drug and alcohol use, the number of drug arrests (possession, manufacturing and sales) and DWI arrests are used. Crime data is from the Maryland State Police, Uniform Crime Reporting Section, Fiscal Year 2002.

The three variables in the analysis are now defined and selected; prevalence, HIV cases and a crime measure. The question is how to assign weights to each variable in the formula. The simplest and least arbitrary approach is to weigh each equally. This allows

[7] See the table on p 5.

[8] For the raw data used to calculate the formula see the Data Appendix.

adjusting for relative difference between the variables. Different regions of the state may require different levels of care as reflected in the proxy variables. For instance, areas with higher HIV rates may reflect a higher number of Injecting Drug Users. Areas with higher drug and DWI arrest may be reflective of other drug-related problems. Weighing all variables equally allows for these differences to be balanced.

The specific formula is as follows:

$$\mathbf{ALLOC_i = 0.33*[(HIV_i/HIV_t)*TxT] + 0.33*[(AR_i/AR_t)*TxT] + 0.34*[(PREV_i/PREV_t)*TxT]}$$ [9]

The following table presents the FY 04 awards to jurisdictions allocated by the formula. It shows the dollar allocation and the percent it represents of the total available funds.

	Formula Allocation	Percent of Total Funds
Allegany	1,054,568	.93%
Anne Arundel	7,701,858	6.8%
Baltimore Co	10,605,618	9.3%
Calvert	1,478,289	1.3%
Caroline	632,383	.6%
Carroll	1,661,173	1.5%
Cecil	1,732,164	1.5%
Charles	2,063,905	1.8%
Dorchester	702,524	.6%
Frederick	3,230,032	2.9%
Garrett	437,151	.4%
Harford	3,140,313	2.8%
Howard	2,473,652	2.2%
Kent	444,573	.4%
Montgomery	8,163,537	7.2%
Prince George's	10,349,254	9.1%
Queen Anne's	709,457	.6%
Somerset	578,698	.5%
St. Mary's	1,626,985	1.4%
Talbot	693,861	.6%
Washington	1,983,751	1.8%
Wicomico	1,864,589	1.6%
Worcester	1,576,326	1.4%
Baltimore City	48,596,783	42.8%
Total	113,501,444	100%

[9] $ALLOC_i$ refers to the allocation to jurisdiction "i" in State "t", TxT refers to the FY 04 allocation of $113,501,444 available for distribution, AR refers to the number of drug and DWI arrests in the jurisdiction or State, HIV refers to the number of HIV cases in the jurisdiction or State, and PREV refers to the estimate of treatment need in the jurisdiction or in the State.

The following table presents a comparison between the current FY 04 awards to jurisdictions and the effect on those awards if allocated by formula.

	Actual FY 04 Award	Formula Allocation	Change (-)
Allegany	2,030,997	1,054,568	(976,429)
Anne Arundel	4,804,781	7,701,858	2,897,077
Baltimore Co	7,067,338	10,605,618	3,538,280
Calvert	1,206,846	1,478,289	271,443
Caroline	655,166	632,383	(22,783)
Carroll	1,526,691	1,661,173	134,482
Cecil	1,432,300	1,732,164	299.864
Charles	2,325,271	2,063,905	(261,366)
Dorchester	1,999,821	702,524	(1,297,297)
Frederick	2,659,842	3,230,032	570,190
Garrett	1,004,729	437,151	(567,578)
Harford	2,138,630	3,140,313	1,001,683
Howard	1,833,196	2,473,652	640,456
Kent	1,979,558	444,573	(1,534,985)
Montgomery	4,704,899	8,163,537	3,458,638
Prince George's	11,496,220	10,349,254	(1,146,966)
Queen Anne's	874,339	709,457	(164,882)
Somerset	1,087,135	578,698	(508,437)
St. Mary's	2,866,769	1,626,985	(1,239,784)
Talbot	938,990	693,861	(245,129)
Washington	3,870,400	1,983,751	(1,886,649)
Wicomico	2,318,868	1,864,589	(454,279)
Worcester	3,107,028	1,576,326	(1,530,702)
Baltimore City	49,571,630	48,596,783	(974,847)
Total	113,501,444	113,501,444	

The formula redistributes $12,566,987 in FY 04 funds. Fifteen jurisdictions had awards reduced by this method and nine had awards increased.

This formula is based solely on the number of individuals in need of treatment, and the social and health effects of addiction. Other variables can be considered in a formula including a jurisdiction's ability to contribute local funding (wealth), as well as a set amount of funds based on population. These are policy choices.

Data Appendix

Subdivision	HIV/AIDS Incidence[1]	DWI Arrests[2]	Drug-Related Arrests[2]	Estimated Treatment Need[3]
Allegany	9	375	544	3,767
Anne Arundel	128	2,305	2,412	29,941
Baltimore City	1,992	1,073	32,056	81,766
Baltimore Co.	290	2,042	3,543	35,519
Calvert	6	839	556	5,413
Caroline	14	201	90	2,537
Carroll	7	526	598	7,709
Cecil	15	904	689	5,860
Charles	13	804	554	9,377
Dorchester	12	191	270	2,591
Frederick	45	1,402	1,250	10,749
Garrett	0	318	183	1,414
Harford	47	1,030	810	12,932
Howard	35	1,106	1,037	7,773
Kent	6	140	131	1,844
Montgomery	263	3,947	2,284	16,988
Prince George's	498	1,619	2,462	22,559
Queen Anne's	7	297	284	2,597
St. Mary's	12	626	570	6,786
Somerset	14	161	186	1,927
Talbot	6	346	252	2,497
Washington	41	673	710	6,446
Wicomico	39	548	684	6,274
Worcester	11	764	1,165	3,765

[1]Maryland AIDS Administration - Maryland HIV/AIDS Epidemiological Profile, April 1, 2001 - March 31, 2002.
[2]Maryland State Police - Uniform Crime Reporting Section, State Fiscal Year 2002.
[3]Maryland Alcohol and Drug Abuse Administration - Estimates of Need Extrapolated from Data on Individuals Treated, State Fiscal Year 2002.